Puget Sound Electrical Workers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

November 1, 2013

TO: **Active Employees, Retirees, Eligible Dependents and COBRA Qualified Beneficiaries covered by the Puget Sound Electrical Workers Healthcare Trust (the "Trust")**

RE: Plan Changes Effective January 1, 2014

This is a summary of material modification describing changes to the Trust's health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Effective January 1, 2014, the Trust's health plan (the "Plan") will no longer be considered "grandfathered" under the Patient Protection and Affordable Care Act (PPACA).

Effective January 1, 2014, the Plan is being amended to satisfy PPACA's requirements for non-grandfathered plans and to make changes, **including a new self-pay requirement for Special Retirees (62 – 65) and a rate increase for both Early Retirees and Medicare Retirees.** These changes are summarized below.

Dependent Eligibility
All dependent children who satisfy the Plan's eligibility requirements will be eligible for dependent coverage, regardless of other available coverage. (The Plan will no longer exclude children who are eligible to enroll for group health coverage through their employer or their spouse's employer.)

Medical Benefits

- Emergency Room Services – The Plan covers certain emergency services provided in hospital emergency rooms when you are suffering from an emergency medical condition. You do not have to obtain prior authorization before seeking emergency services in a hospital emergency room. The Plan will charge you the same coinsurance whether you obtain those services in the emergency room of a PPO hospital or a non-PPO hospital. However, if you obtain those services in a non-PPO hospital, the provider may bill you the difference between what the provider charges and what the provider collects from the Plan and from you in the form of copayment and coinsurance payment.

- Percentage Payable – For services incurred on and after January 1, 2014, the Plan will increase the overall deductibles for both PPO providers and non-PPO providers. The Plan will also increase your coinsurance level for all medical services. These changes are reflected on the enclosed Summary of Benefits and Coverage.

- Preventive Care Services - The Plan will pay 100% of the costs incurred for certain preventive care services when those services are provided by a PPO provider. This means that these services will not be subject to any deductible, and you will not have to pay any cost sharing (in other words, you will not have to pay coinsurance for these services). The preventive care services to which this new rule applies are those that are recommended under the Affordable Care Act. The required services include services that are highly recommended by the U.S. Preventive Services Task Force (for example, screening mammography every 1-2 years for women age 40 and older and colorectal cancer screening at specified intervals for adults age 50 to 75). In addition, certain pediatric preventive services, for example, well baby and well child visits at specified intervals, will be covered. You will also have coverage for immunizations for infants, children, adolescents, and adults as recommended by the Federal Centers for Disease Control and Prevention. A complete list can be reviewed at www.uspreventiveservicestaskforce.org.

  Preventive care services performed at a non-PPO provider continue to be subject to the Plan deductible and coinsurance.

(over)

The Preventive Care Services Benefit also includes a limited number of over-the-counter pharmaceuticals, paid at 100% when prescribed by your physician and purchased through the Plan's pharmacy network. These include:

- aspirin (325 mg and 81 mg) for cardiovascular disease for men and women
- folic acid (0.4 mg and 0.8 mg) supplements for women
- smoking cessation products are covered at 100% when prescribed by a physician and purchased through the Plan's pharmacy network

Please check with the Administration Office or Envision Rx Options (the Pharmacy Benefit Manager) for limitations that may apply.

- Preventive Care Services for Women – Effective January 1, 2014, the Plan will cover these preventive care services for women without any cost-sharing when they are provided by a PPO provider and in accordance with applicable recommendations and guidelines, a complete list can be reviewed at http://www.hrsa.gov/womensguidelines/:
  - Well-woman visits
  - Gestational diabetes screening
  - Human papillomavirus DNA testing, every three years for women age 30 or older
  - Sexually transmitted infections counseling for sexually-active women
  - Human immunodeficiency virus (HIV) screening and counseling for sexually active women
  - Access to all Food and Drug administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
  - Breastfeeding support, supplies, and counseling
  - Interpersonal and domestic violence screening and counseling.

Dental Benefits

Effective January 1, 2014, the annual dental benefit allowance will be reduced from $2,500 to $2,000. ***Note:*** Not all participants are eligible for dental benefits. Please check your Summary Plan Description Booklet or contact the Administration Office for verification of dental eligibility.

Special Retirees Ages 62 – 65 (Free) – Self-Pay Requirement

Retiree Plan participants in this category, whose eligibility effective dates were December 1, 2013, or earlier, will now have a self-pay requirement. Effective with January 2014 coverage, payment due December 15th, and the cost for coverage will be $200 per month for Member Only coverage and $400 for Member/Spouse coverage.

Retiree Plan participants whose eligibility effective date is January 1, 2014, or later, will have a self-pay requirement of $358 per month for Member Only coverage and $716 per month for Member/Spouse coverage.

The Administration Office will send a separate notification of this self-pay requirement to all affected Retiree Plan participants.

Early Retirees and Medicare Retirees Rate Increase

Effective with January 2014 coverage, payment due December 15th, Early Retirees self-pay rate will increase to $600 per month for Member Only coverage and $1,200 per month for Member/Spouse coverage. Medicare Retirees self-pay rate will increase to $358 per month for Member Only coverage and $716 per month for Member/Spouse coverage. The Administration Office will send a separate notification of these rate increases to all affected Retirees.

External Review of Certain Claim Appeals

Effective for healthcare benefit claims appeals reviewed on or after January 1, 2014, a benefit claimant whose appeal is denied by the Board of Trustees issues may request an external review of certain healthcare benefit claim denials by an independent review organization (IRO). The types of appeals that an IRO may consider must involve medical judgment or the retroactive termination ("rescission ") of healthcare benefits or coverage. There is no external review for weekly disability, accidental death and dismemberment, or life insurance benefits. The rules governing external review will be included in an update to the Summary Plan Description Booklet.

If you have any questions, regarding plan changes, please contact the Administration Office at (866) 314-4239 or (206) 441-4667, option 1. Questions regarding Retiree rate changes call extension 3322.

Board of Trustees
Puget Sound Electrical Workers Healthcare Trust

Enclosure: Summary of Benefits and Coverage for 1/1/2014 – 7/31/2014